



STATE OF MISSOURI
OFFICE OF ADMINISTRATION
RISK MANAGEMENT SECTION
AUTOMOBILE LOSS NOTICE

RISK MANAGEMENT SECTION OFFICE OF ADMINISTRATION P.O. BOX 809 JEFFERSON CITY, MISSOURI 65102 TELEPHONE NUMBER (573) 751-4044 FAX NUMBER (573) 751-7819		This form must be completed for the Risk Management office to start a file. Please complete and fax or mail this form to Risk Management within 24-48 hours of the accident. PLEASE PRINT CLEARLY OR TYPE.				
REMARKS		FOR OFFICE USE ONLY				
REPORTING AGENCY						
STATE DEPARTMENT				PERSON TO CONTACT FOR QUESTIONS REGARDING THIS CLAIM		
ADDRESS				NAME _____		
CITY	STATE	ZIP CODE	CONTACT'S BUSINESS PHONE (A/C, NO., EXT.) _____			
SAM II AGENCY NUMBER	SAM II ORG NUMBER	AGENCY PHONE (A/C, NUMBER) _____				
ACCIDENT INFORMATION						
LOCATION OF ACCIDENT (INCLUDING CITY & STATE)		POLICE CONTACTED (Y/N) AND REPORT NO.		VIOLATIONS/CITATIONS		
DATE (MM/DD/YY) & TIME OF LOSS		PREVIOUSLY REPORTED	DESCRIPTION OF ACCIDENT (USE REVERSE SIDE, IF NECESSARY) THIS IS REQUIRED.			
		A.M.			YES	
		P.M.			NO	
STATE VEHICLE INFORMATION						
YEAR	MAKE	MODEL	V.I.N. (VEHICLE IDENTIFICATION)	PLATE NUMBER		
OWNER'S NAME AND ADDRESS				PHONE (A/C, NO., EXT.)		
DRIVER'S NAME AND ADDRESS (CHECK IF STATE EMPLOYEE) <input type="checkbox"/>			DRIVER'S SOCIAL SECURITY # REQUIRED	BUSINESS PHONE (A/C, NO., EXT.)		
RELATION TO INSURED (EMPLOYEE, FAMILY, ETC.)	DATE OF BIRTH	DRIVERS LICENSE NUMBER	PURPOSE OF USE	USED WITH PERMISSION <input type="checkbox"/> YES <input type="checkbox"/> NO		
DESCRIBE DAMAGE	ESTIMATE AMOUNT \$	WHERE CAN VEHICLE BE SEEN	OTHER INSURANCE ON VEHICLE <input type="checkbox"/> YES <input type="checkbox"/> NO			
OTHER VEHICLE INVOLVED OR PROPERTY DAMAGED IN ACCIDENT						
DESCRIBE PROPERTY (IF AUTO, YEAR, MAKE, MODEL, PLATE NO.)		OTHER VEH. OR PROP. INSURED <input type="checkbox"/> YES <input type="checkbox"/> NO	COMPANY OR AGENCY NAME AND POLICY NUMBER			
OWNER'S NAME AND ADDRESS		BUSINESS PHONE (A/C, NO., EXT.)	RESIDENCE PHONE (A/C, NO.)			
OTHER DRIVER'S NAME AND ADDRESS (CHECK IF SAME AS OWNER) <input type="checkbox"/>		BUSINESS PHONE (A/C, NO., EXT.)	RESIDENCE PHONE (A/C, NO.)			
DESCRIBE DAMAGE	ESTIMATE AMOUNT \$	WHERE CAN DAMAGE BE SEEN				
INJURED						
NAME AND ADDRESS	PHONE (A/C, NO.)	PED	INS. VEH.	OTHER VEH.	AGE	EXTENT OF INJURY
WITNESSES OR PASSENGERS						
NAME AND ADDRESS	PHONE (A/C, NO.)	INS. VEH.	OTHER VEH.	OTHER (SPECIFY)		
REMARKS						
FORM COMPLETED BY (PLEASE PRINT)					SIGNATURE	